

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03981

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03974

1. DECEASED-NAME (Type or print) First Middle Last Amanda Irene Bostic			2a. DATE OF DEATH Month Day Year Mar 3 1969			2b. HOUR 3:20 PM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 2, 1907		6. AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Kent Co., Chestertown Md.					
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Queen Anne's Price			13c. CITY OR TOWN Price		13d. INSIDE CITY LIGHTS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last Garrett Jefferson Cahall			15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth NMN Kenton								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. (If yes give year or dates of service) 216-48-5249			17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A.S. CARDIO-VASCULAR DISEASE. DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH FEW MINUTES MANY YEARS 20 YEARS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Feb. 28, 1969 , to Mar 3, 1969 , that (I) (we) last saw the deceased alive on Mar 3, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. A. Oteiza						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED MARCH 4-69			
22d. PHYSICIAN'S NAME (Type) J. A. Oteiza, M.D.						22e. ADDRESS Chestertown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE March 6		23c. NAME OF CEMETERY OR CREMATORY Sudlersville			23d. LOCATION (City or Town) (County) (State) Sudlersville Q.A. Md.			
24. FUNERAL DIRECTOR Alyce R. Lane						ADDRESS Church Hill, Md.		25a. REC'D BY REGISTRAR DATE MAR 6 1969		25b. REGISTRAR'S SIGNATURE <i>Chambers</i>	

THE CITY OF NEW YORK,
IN SENATE,
January 1, 1888.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE,
MAY 1, 1887.
ALBANY:
J. B. LIPPINCOTT & CO.,
PRINTERS,
1888.

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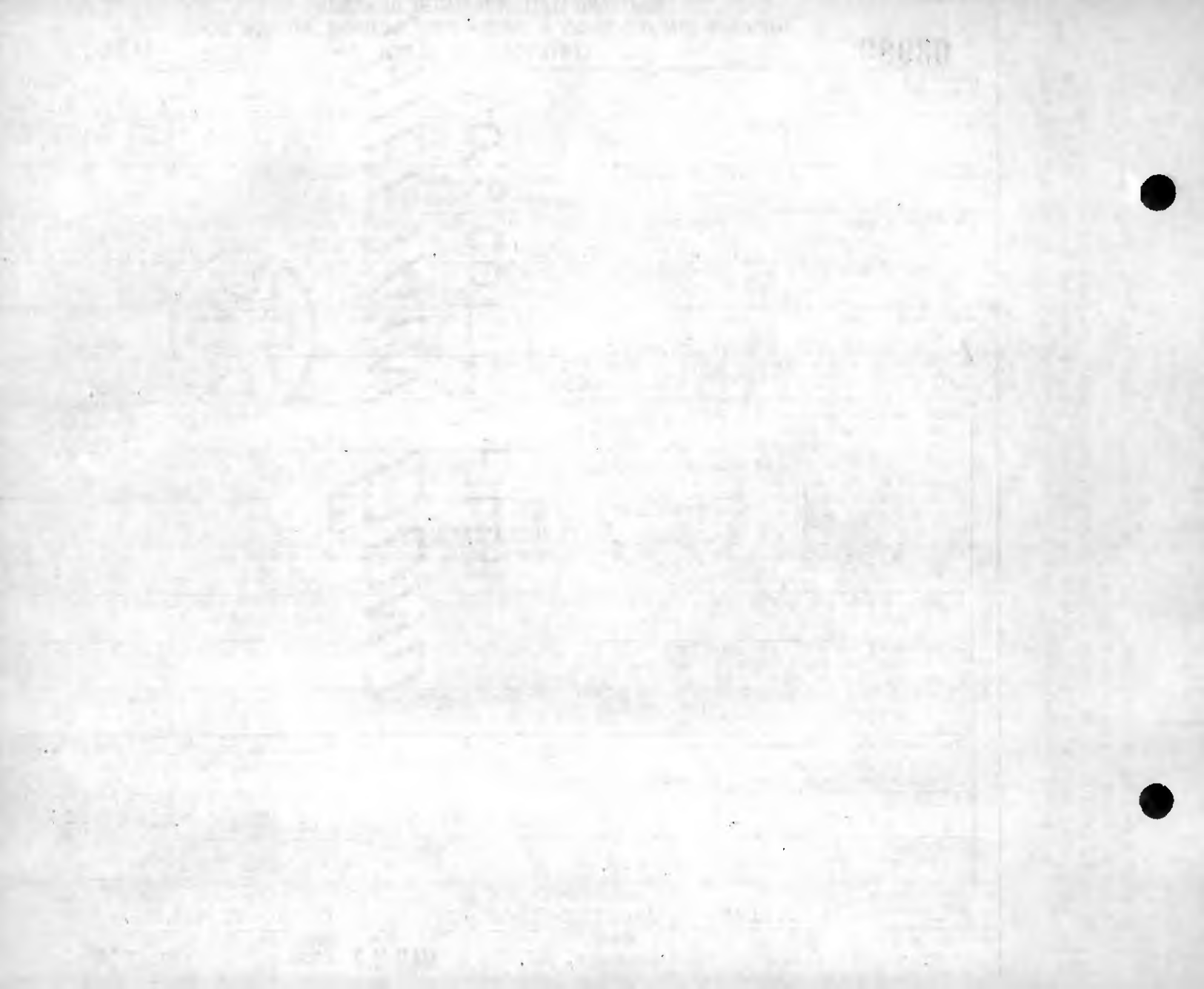
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03982

CERTIFICATE OF DEATH

03975

1. DECEASED-NAME (Type or print) First Middle Last Hans Ernest Fischer			2a. DATE OF DEATH Month Day Year March 22, 1969		2b. HOUR 6:40 P
3. SEX Male	4. RACE White	5. DATE OF BIRTH 6/18/03		6. AGE (In years lost birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Germany	7b. CITIZEN OF WHAT COUNTRY? XX US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent Md.		
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Hosiery Mill owner	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland		13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Flatland Road
14. FATHER'S NAME First Middle Last Karl IMN Fischer			15. MOTHER'S MAIDEN NAME First Middle Last Freda IMN Andra		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. ? 163 10 0481		17. INFORMANT Hospital Records Chestertown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute renal failure</u> 4279 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ventricular tachycardia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes mellitus - Coronary Artery Disease (years)</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>5-12</u> , 19 <u>69</u> , to <u>3-22</u> , 19 <u>69</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>3-22</u> , 19 <u>69</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Harry Paul Ross</u>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3-24-69	
22d. PHYSICIAN'S NAME (Type) Harry Paul Ross, M.D.		22e. ADDRESS Chestertown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/24/1969	23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City or Town) (County) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR J. Willis Wells		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR MAR 27 1969	25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03976

1. DECEASED NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF ESTI- DEATH MATED		Month	Day	Year	2b. HOUR
Jefferson				Freeman	18.		3	29	1969	M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. IF UNDER 1 YEAR MONTHS DAYS	7. IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR		
Male	Colored	8/13/1902	66 YRS.			3 29 1969		M		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OF DEATH		
Maryland		U.S.A.				Kent County		Md		
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Chestertown		Kent & Queen Anne's Hospital		Labor		Various				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER				
Maryland		Kent		Bultertown		R.F.D. #1 Worton, Md.				
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost	
Jefferson				Freeman Sr.	Mary			Etta		Walker
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		ADDRESS				
No		220-22-2132		Mrs. Maggie Freeman		Worton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4109 PRESUMABLY MYOCARDIAL INFARCTION - 10 MIN</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4109</u> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>- 10 MIN</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> Acting DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 3-31-69				
O. S. Gulbrandsen M. D.		Chestertown, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial		4/4/69		Mt. Olive Cemetery		Bultertown Kent		Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
Kenneth W. Day		Chestertown, Md.		APR 3 1969		H. Charles Judge				

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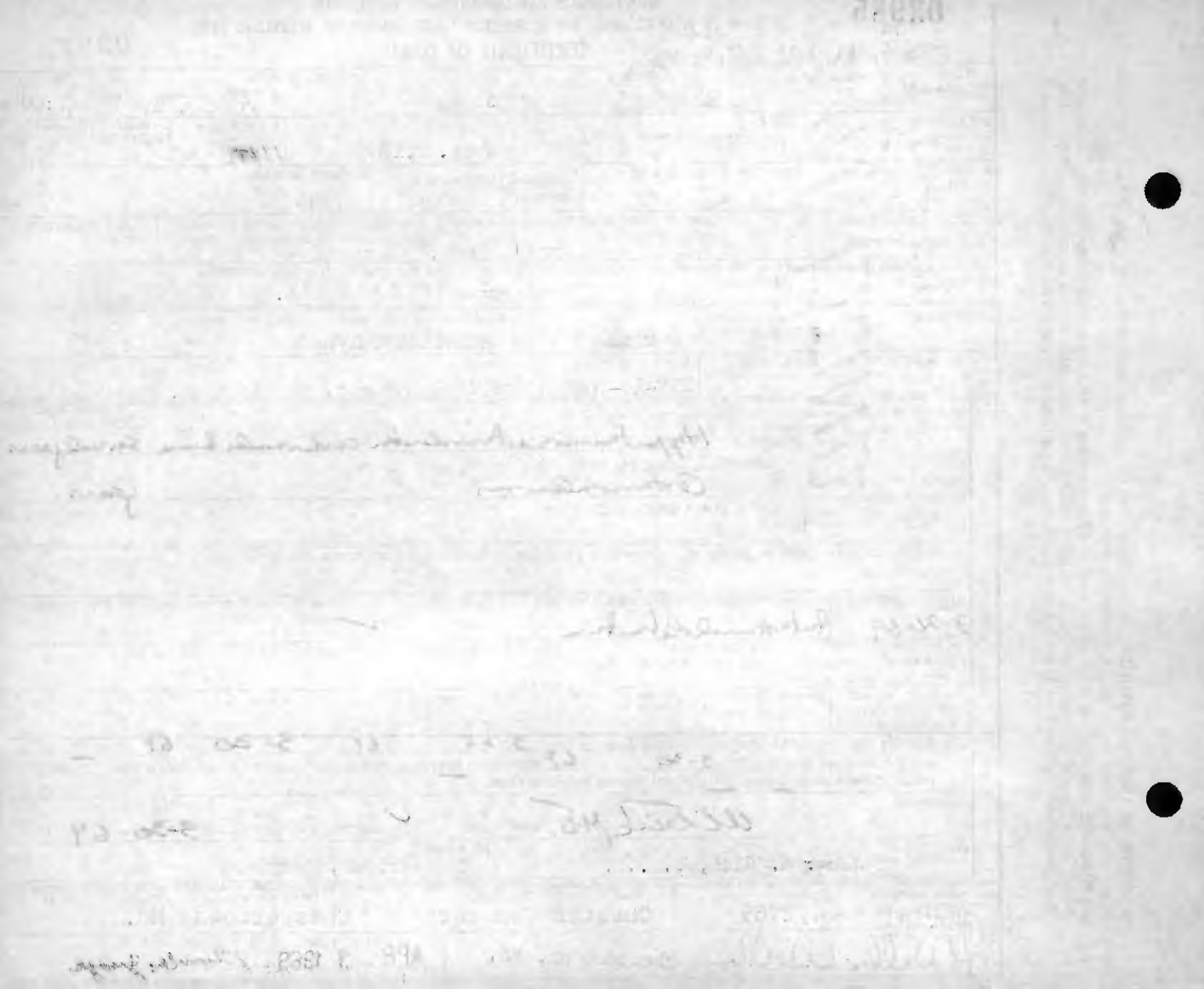
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
MYRTLE			LILLIAN			HAWKINS			Month Day Year March 2 1969 8:25 AM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7		W		1/19/1904			65 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland		U.S.A.					Kent Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Chesertown			Kent & Queen Annes			H-Wife			Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER
Maryland			Queen Anne's			Queenstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Bennett Pt. Rd.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
William			Godman			Daisy Armiger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			
No			220-07-1091			Hospital Records Chesertown Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH CAUSED BY:									
IMMEDIATE CAUSE (a) Cerebral vascular hemorrhage or stroke									
4122 DUE TO, OR AS A CONSEQUENCE OF									
(b) Severe Hypertension Cardiovascular disease									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			HOUR A.M. Month Day Year						
(If either, notify medical examiner)			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			
While <input type="checkbox"/> Not while <input type="checkbox"/>						Street or R.F.D. No. City or Town County State			
at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from March 22, 1969, to March 2, 1969, that (I) (we) lost saw the deceased alive on March 2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Robert W. Farr						DEGREE		3-2-69	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
ROBERT W. FARR						CHESTERTOWN, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			3-5-69		Friendship		Anne Arundel Md.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Leonard J. Ruck, Inc., 5305 Harford Rd.						DATE MAR 3 1969		Charles J. Ruck	

18880

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03985										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03978									
Item #6, Film G111 L/7/69 km										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print) First Middle Last Lida IRON Hiron					2a. DATE OF DEATH Month Day Year March 30, 1969					2b. HOUR 7:00 P.M.																			
3. SEX Female			4. RACE White			5. DATE OF BIRTH Aug. 5, 1897			6. AGE (In years last birthday) 71 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.														
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? US			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Kent Md.																				
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife			12b. KIND OF BUSINESS OR INDUSTRY																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Kent			13c. CITY OR TOWN Chestertown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER Rt. 3																	
14. FATHER'S NAME First Middle Last Batesman? Hendrix?					15. MOTHER'S MAIDEN NAME First Middle Last Araminta? Lynch?																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 212-16-7044			17. INFORMANT Address Hospital Records, Chestertown, Maryland																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperfunction arteriosclerotic cardiovascular disease</u> 4122 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several years years.																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION 3-26-69					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 3-25, 1969, to 3-30, 1969, that (I) (we) last saw the deceased alive on 3-30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE A. C. Dick, M.D.										22c. DATE SIGNED 3-30-69					22d. ADDRESS Chestertown, Maryland														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE 4/2/69					23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery					23d. LOCATION (City or Town) (County) (State) Chestertown, Md.														
24. FUNERAL DIRECTOR J. Wells										ADDRESS Chestertown, Md.					25a. REC'D BY REGISTRAR APR 3 1969					25b. REGISTRAR'S SIGNATURE Charles Young									



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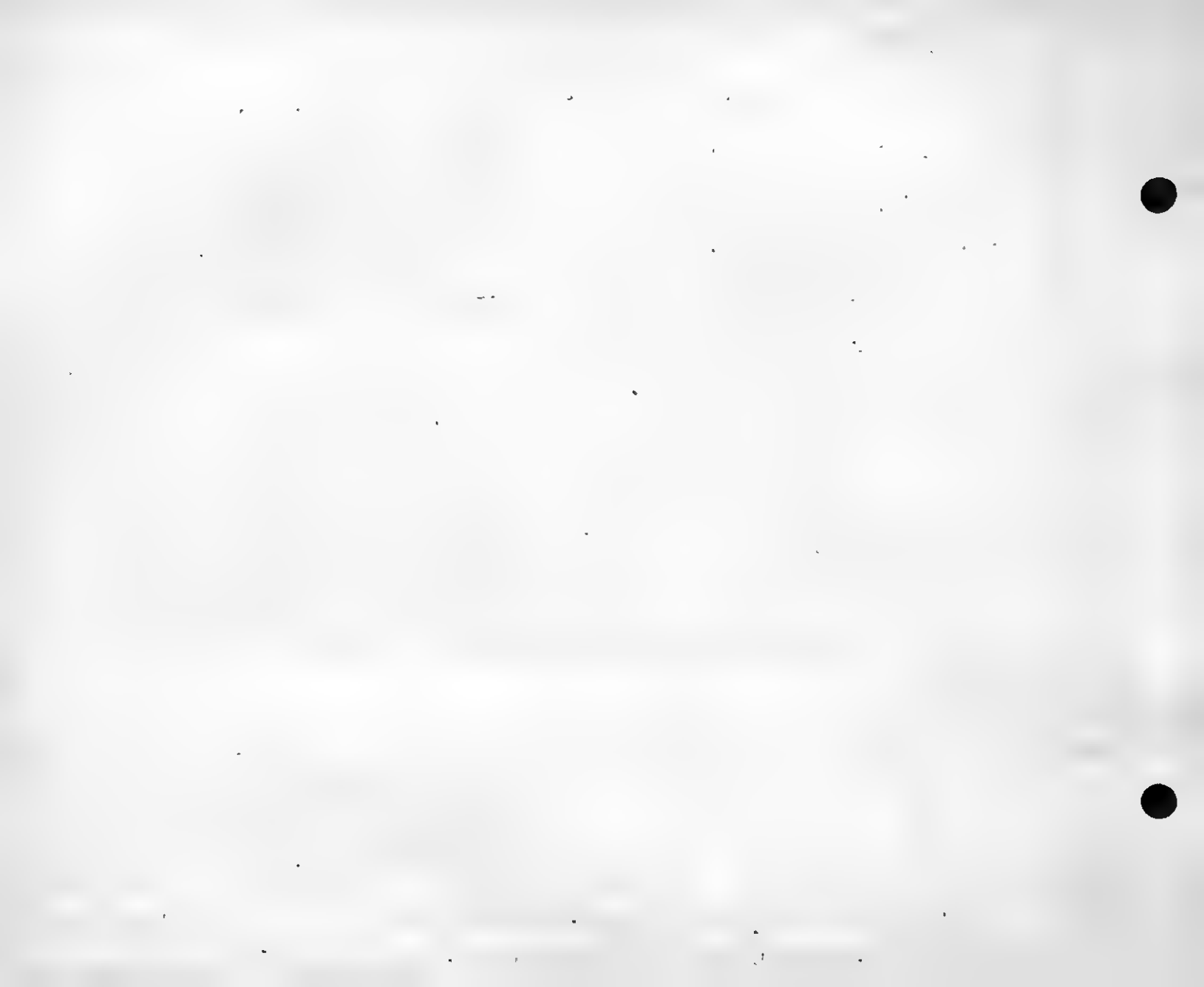
03986

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03979

1. DECEASED NAME (Type or print) Charles S. Jacquette			2a. DATE OF DEATH Month Mar. Day 23 Year 1969			2b. HOUR 2 P.M.	
3 SEX male		4 RACE white		5. DATE OF BIRTH 11/28/1891		6 AGE (In years last birthday) 77 YRS.	
7a. BIRTHPLACE (State or foreign country) Kent Co. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Kent Md.	
10 CITY OR TOWN OF DEATH near Rock Hall		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) At Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer owner		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Rural		14. FATHER'S NAME First James Bird Middle Jacquette Last Jacquette		15. MOTHER'S MAIDEN NAME First Isabel Middle Sparks Last Sparks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 215 38 0474		17 INFORMANT Mrs. Addie Warner Jacquette		Address Rock Hall, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 7107 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) myocardial infarction							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ✓
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Arthritis Chronic							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 1 , 19 63 , to March 23 , 19 69 , that (I) (we) last saw the deceased alive on March 22 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. March 25/69							
22b. SIGNATURE Norbert C. Nitsch		22c. PHYSICIAN'S NAME (Type) Norbert C. Nitsch		22d. ADDRESS Rock Hall, Md.		22e. DATE SIGNED 3/24/1969	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/26/69		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.		23d. LOCATION (City or Town) (County) (State) near Rock Hall, Md.	
24. FUNERAL DIRECTOR Wells Wells		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR 27 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

03987

03980

1. DECEASED NAME (Type or print) Laura Jeannette Kinsey			2a. DATE OF DEATH Month 3 -13 Day 1969		2b. HOUR 9:41 P
3. SEX Female	4. RACE White	5. DATE OF BIRTH 7/25/89		6. AGE (In years last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent		
10. CITY OR TOWN OF DEATH Stevensville,	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1 Bayside Dr., Bay City	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) none	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.	13b. COUNTY Kent	13c. CITY OR TOWN Stevensville	13d. INSIDE CITY, ALLEY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 1 Bayside Dr., Bay City	
14. FATHER'S NAME First Middle Last George W. Smith		15. MOTHER'S MAIDEN NAME First Middle Last Carrie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Bay City, Stevensville, Md. Mr. Allan S. Kinsey, Jr. 1 Bay Side Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 7-28 , 1968 , to 3-13 , 1969 , that (I) (we) last saw the deceased alive on 3-12 , 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ralph E. Libby MD		22c. DATE SIGNED 3-14-69	22d. PHYSICIAN'S NAME (Type) Ralph E. Libby, M.D.		
22e. ADDRESS Grasonville, Maryland		22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/17/69	23c. NAME OF CEMETERY OR CREMATORY Loudon Park, Md.	23d. LOCATION (City or Town) Baltimore, Md.	(County) (State)	
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229		25. REC'D BY REGISTRAR MAR 17 1969		26. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
03988					CERTIFICATE OF DEATH					03981				
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		P			
Patsy			Ann		Lenger	Month 3 Day 31 Year 1969			6:00		M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
Female		White		1-3-42		27 YRS.		MONTHS		DAYS				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH					
Maryland			USA						Kent Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Chestertown			Kent Queen Anne's Hosp.			Nurse								
13a. USAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
Maryland			Kent			Chestertown						123 Queen St.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last			
Andrew			Jackson	Taylor		Mary			Inna	Thomas				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT								
no			213-42-0274			Hospital Records								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured aneurysm rt. aortic arch</u>														
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe hypertensive disease</u>										8 yrs.				
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
<u>early advanced atherosclerosis</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
22a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>3-31</u> , 19 <u>69</u> , to <u>3-31</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-31</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS			22e. DATE SIGNED					
<u>Harry P. Ross M.D.</u>			Harry P. Ross M.D.			Chestertown, Md.			4-1-69					
23a. BURIAL CREMATION REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			April 3, 1969			Galena Cemetery.			Galena, Kent, Md.					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Edward Fellows & Son. Millington, Md. 21651						DATE APR 7 1969		<u>Charles Judge</u>						

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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03989		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03982	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH ESTIMATED	
FRANCES BACON NEEDLES						3/14/69 19	
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD	
female	white	9/16/1899	69 YRS			3/14/69 19	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
Maryland		USA				Kent	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Chestertown		307 High St.		Cashier & Clerk		Store	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		Kent		Chestertown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO	
George F. Bacon		Alice Miller		no		213 14 6768	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
Horace Needles		Presumably Coronary Thrombosis					
Chestertown, Md.		PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF		20. AUTOPSY?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(b) Arteriosclerotic Cardiovascular Disease		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		minutes	
		(c)				2 yrs +	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
Chronic nephritis with uremia							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		21d. INJURY OCCURRED	
CAUSE OF DEATH		19				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	
21f. LOCATION Street or R.F.D. No		21g. LOCATION City or Town		21h. LOCATION County		21i. LOCATION State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. DATE SIGNED		22c. CHIEF MEDICAL EXAMINER		22d. ASSISTANT MEDICAL EXAMINER	
3/15/69		Acting		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		3/18/69		Chester Cemetery		Chestertown, Md.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	
J. Wilks Wells		MAR 18 1969		Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03990

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03983

1. DECEASED NAME (Type or print) First Middle Last Ada Blanche Scott			2a. DATE OF DEATH Month Day Year Mar 24 1969			2b. HOUR 7:35AM						
3. SEX Female		4. RACE White		5. DATE OF BIRTH Aug 8, 1899		6. AGE (in years last birthday) 69 YRS.		7. UNDER 1 YEAR MONTHS DAYS 69		8. UNDER 24 HRS HOURS MIN 69		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Kent			
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Kent & Queen Anne's Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Baby-sitting			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 416 High St.			
14. FATHER'S NAME First Middle Last Edward Watson			15. MOTHER'S MAIDEN NAME First Middle Last Daisy Kendall									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO 217 16 9156			17. INFORMANT Address Mrs. Dorothy S. Parsons Chestertown Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MENINGOCOCCAL MENINGITIS 0360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Mar 20, 1969 , to Mar 24, 1969 , that (I) (we) last saw the deceased alive on Mar 24, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death												
22b. SIGNATURE H. P. Ross M.D.						22c. DATE SIGNED 3-25-69		22d. PHYSICIAN'S NAME (Type) H. P. Ross, M.D.			22e. ADDRESS Chestertown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3/26/69		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.			23d. LOCATION (City or Town) (County) (State) Rock Hall, Md.				
24. FUNERAL DIRECTOR W. Williams						25a. REC'D BY REGISTRAR MAR 27 1969		25b. REGISTRAR'S SIGNATURE W. Williams				

FOR STATE
HEALTH DEPT.

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03991

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03984

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
Steven Ricardo Seney						ESTIMATED <input type="checkbox"/> MONTH Day Year 3 29 1969			M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years just birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR
Male	Colored	12/21/68	31 yrs	MONTHS	DAYS	HOURS	MIN	Month Day Year 3 29 19 69			M
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md		
Maryland		U.S.A.				Kent County					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Chestertown			Kent & Queen Anne's Hospital								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY L.M. IS?		
Maryland			Kent			Chestertown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			17 INFORMANT			ADDRESS		
Godford Seney			Susie Thomas			Mrs. Susie Seney St. Chestertown, Md.			106 Lynchburg Street		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS		
No			None			Mrs. Susie Seney St. Chestertown, Md.			106 Lynchburg Street		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										UNKNOWN	
IMMEDIATE CAUSE (a) PRESUMABLY SEPTICEMIA											
5177 DUE TO, OR AS A CONSEQUENCE OF										11	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										RESPIRATORY INFECTION	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. P.M. 19								
21d INJURY OCCURRED			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						by DR. SCHMIDT, EASTON					
22a. I certify that I took charge of the remains described above, held on death resulted from: Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			M.D.			22b DATE SIGNED					
EXAMINER'S NAME (Type)			O.S. Gulbrandsen M. D.			3-31-69					
			ACTING			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) Chestertown, Md.		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Burial			4/1/69		Bethel A.M.E. Cem.			Pondtown Queen Anne's Md			
24 FUNERAL DIRECTOR						ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Jennette Wally						Chestertown, Md.		APR 3 1969		J. Williams Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03992

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03985

1 DECEASED NAME (Type or print) First Middle Last Lucy MIN Solloway			2a DATE OF DEATH Month 3 Day 2 Year 69			2b HOUR 6:35 P						
3. SEX Female		4 RACE White		5. DATE OF BIRTH Dec. 13, 1881		6 AGE (In years last birthday) 87 YRS		7c UNDER 1 YEAR MONTHS DAYS		7d UNDER 24 HRS. HOURS MIN		
7a BIRTHPLACE (State or foreign country) England		7b CITIZEN OF WHAT COUNTRY? US		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Kent Md.						
10 CITY OR TOWN OF DEATH Chestertown			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if in institution, residence before admission) STATE Maryland			13b COUNTY Kent		13c CITY OR TOWN Worton		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Catt's Corner			
14 FATHER'S NAME First Middle Last William Henry Wells			15 MOTHER'S MAIDEN NAME First Middle Last Annie BEN Fisher									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) 16 (If yes give year or dates of service)			16b SOCIAL SECURITY NO. 220 16 9234		17 INFORMANT Hospital Records			Address Chestertown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary atherosclerosis disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Several years.</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes</i>												
19a. DATE OF OPERATION 2-28-69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Reluctant (Religiosity)</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from _____, 1969, to _____, 1969, that (I) (we) last saw the deceased alive on _____, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>A.C. Dick</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 3-2-69				
22d. PHYSICIAN'S NAME (Type) A. C. Dick, M.D.				22e. ADDRESS Chestertown, Md.								
23a. BURIAL, CREMATION, REMOVAL (specify) Burial		23b. DATE 3/6/69		23c. NAME OF CEMETERY OR CREMATORY Chester Cem.		23d. LOCATION (City or Town) (County) (State) Chestertown, Md.						
24. FUNERAL DIRECTOR J. Willis Wells, Chestertown, Md.				25a. REC'D BY REGISTRAR DATE MAR 7 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

03993

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03986

1. DECEASED-NAME (Type or print) William Romaine Wagner			2a. DATE OF DEATH Month March Day 25 Year 1969			2b. HOUR 3 P. M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 20, 1905		6. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Kent Md.			
10. CITY OR TOWN OF DEATH Rock Hall		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) xxx			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Plumber			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER xxx	
14. FATHER'S NAME First Middle Last William M. Wagner			15. MOTHER'S MAIDEN NAME First Middle Last Rachel Virginia Atkinson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO. 218-05-8177		17. INFORMANT Address Mrs. Anna Hurst--Newark, Delaware				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4124 DUE TO, OR AS A CONSEQUENCE OF Cardio Vascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from March 17, 1969 , to March 24, 1969 , that (I) (we) last saw the deceased alive on March 24, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Norbert C. Nitsch				22c. DATE SIGNED 3-26-69		22d. PHYSICIAN'S NAME (Type) Norbert C. Nitsch			
22e. ADDRESS Rock Hall, Maryland				22f. ADDRESS Rock Hall, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE March 28		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		23d. LOCATION (City or Town) (County) (State) Rock Hall, Maryland			
24. FUNERAL DIRECTOR Alice R. Lane				ADDRESS Church Hill, Md.		25a. REC'D BY REGISTRAR DATE APR 1 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

03220

RECEIVED

DATE: 10/10/1960

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

DATE: 10/10/1960

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

DATE: 10/10/1960

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

DATE: 10/10/1960

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
03994						CERTIFICATE OF DEATH						03987	
1. DECEASED-NAME (Type or print) First Middle Last JAMES ALLEN Webb						2a. DATE OF DEATH Month Day Year MARCH 30 1969				2b. HOUR 8:48 AM			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MAY 21, 1950		6. AGE (In years lost birthday) 18 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH KENT CO. Md.							
10. CITY OR TOWN OF DEATH CHESTERTOWN, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) KENT Queen Anne's				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) STUDENT			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY KENT CO.		13c. CITY OR TOWN Kennedyville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
14. FATHER'S NAME First Middle Last CARL (NMN) Webb Jr.		15. MOTHER'S MAIDEN NAME First Middle Last MARY Elizabeth Boyd		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 218-50-1175		17. INFORMANT Hospital Records, Chestertown Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LIVER FAILURE 075X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) INFECTIOUS MONONUCLEOSIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 DAYS 4 WEEKS													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (1) (this hospital) attended the deceased from 3-15, 1969 , to 3-30, 1969 , that (1) (we) last saw the deceased alive on 3-30, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE DR. Oteiza M.D. DEGREE		22c. DATE SIGNED 3-30-69		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (Type) JORGE A. OTEIZA		22e. ADDRESS CHESTERTOWN - Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 2, 1969		23c. NAME OF CEMETERY OR CREMATORY Still Pond Cemetery.		23d. LOCATION (City or Town) (County) (State) Still Pond, Kent, Md.							
24. FUNERAL DIRECTOR Edward Fellows				ADDRESS Millington, Md.		25a. REC'D BY REGISTRAR APR 3 1969		25b. REGISTRAR'S SIGNATURE Richard J. Gage					

DATE: 10/10/1960

TIME: 10:10 AM

LOCATION: 10:10 AM

REMARKS: 10:10 AM

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